State of Connecticut
GENERAL ASSEMBLY

Commission on Children

TESTIMONY
COMMITTEE ON CHILDREN PUBLIC HEARING
TUESDAY, FEBRUARY 16, 2016

SUBMITTED BY STEVEN HERNÁNDEZ, ESQ.
DIRECTOR OF PUBLIC POLICY AND RESEARCH

Honorable Co-chairs, Senator Bartolomeo and Representative Urban, Ranking and other esteemed members of the Committee on Children:

My name is Steven Hernández, Attorney and Director of Public Policy and Research for the Legislature's Commission on Children.

We are testifying today to offer our strong and unqualified support for Raised HB-5141, An Act Concerning Concussions And Youth Athletic Activities Conducted On Public Athletic Fields.

As we testified last year on a similar measure, youth concussion laws are about accountability, and in the case of this proposal, best practices. In fact, I'd like to incorporate by reference our testimony from last year on the question of liability. The law, and our testimony, is clear on the matter.

A concussion is a traumatic brain injury. The facts about concussion injuries are clear, but they bear repeating: 3,800,000 concussions were reported in 2012, double what was reported in 2002;

33% of all sports concussions happen at practice; 39% is the amount by which cumulative concussions are shown to increase catastrophic head injury leading to permanent neurologic disability; 47% of all reported sports concussions occur during high school football; 1 in 5 high school athletes will sustain a sports concussion during the season; 33% of high school athletes who have a sports concussion report two or more in the same year; 4 to 5 million concussions occur annually, with rising numbers among middle school athletes; 90% of most diagnosed concussions do not involve a loss of consciousness; and an estimated 5.3 million Americans live with a traumatic brain injury-related disability (CDC)

The state of Connecticut has crossed the Rubicon on concussion safety. In 2010 the state mandated concussion education for high school coaches, along with remove-from-play and return-to-play protocols. This proposal would not go as far, but by ensuring that coaches are trained and parents are informed on the dangers of concussions, we move one step closer to ensuring that children exposed to injury on our public playing fields are supervised and attended to by adults trained in the state of the art regarding concussion safety.

The Commission also supports, but will not testify on, other bills before the Committee today, including proposed Governor's Bill No. 10 on childhood homelessness, H.B. 5137on exempting disposable or reusable diapers from the sales tax, and 5140 regarding therapy animals for children testifying in certain criminal cases. At your request we would be happy to submit more specific testimony on our support for these proposals.

The Commission on Children supports the Governor's Bill No 10 (or LCO No 365), An Act Increasing Access to Childcare for Children Who Are Homeless. We serve on the Early Childhood Cabinet and its Subcommittee on homelessness. Together the members worked with experts, parents and agencies to cull the numbers and necessary policies to reduce homelessness among our youngest generation. In spite of our desires for child stability and safety, there are a surprisingly high number of young parents with young children who experience homelessness each year. This is a telltale phenomenon regarding employment and affordable housing challenges.

In some communities, half of the homeless parents are under twenty-five years of age. In CT, there are 1600 families with young children who live in an emergency shelter, transitional housing, domestic violence shelter or substance abuse treatment facilities system. Poverty is known to have an unfair impact on children in their health, safety and learning. Children who are homeless have much higher rates of developmental delays than children who are not homeless. We have worked together to address better identification of families, improved case management, two generational programming and access to services. This of course, includes child care. If a parent is homeless, he or she cannot find housing, seek employment, deeply address trauma or build the necessary family supports to move out of crisis.

Homeless families need to be eligible for the Care4 Kids child care subsidy. Requirements that make it impossible for eligibility, such as employment, need to be removed. Families need to have priority without the burden of residency, which is tantamount to a denial if one is homeless. Similarly, there needs to be a grace period for child

health documentation required by child care licensing to allow for immediate enrollment of homeless children in a licensed child care setting. LCO365 makes homeless families categorically eligible for the Care4Kids child care subsidy. As the children are the most at risk, this effort is laudable.

However, good policy often has unintended consequences. Demand for early care slots will surpass supply with this new cohort of eligible homeless families. This will unnecessarily pit the parent who is working against the parent who is homeless for necessary child care. There is also growing interest among low-income parents who are seeking childcare eligibility while they take courses so they can more skillfully enter a competitive market and build economic stability.

We recommend, instead of pitting one low-income family cohort against another, we creatively look at improved and more intentional utilization of our TANF dollars and SNAP E & T dollars to expand our resources for child care. SNAP E & T allows draw down for child care for non-TANF low-income families using SNAP. TANF dollars can be transferred to child care. Connecticut currently utilizes our TANF dollars less for employment and child care than for a category called "Other." Perhaps with more intentional direction, we can help an increasing number of poor and low-income parents use child care to improve their lot in housing, schooling and employment. This in turn, will help children thrive.

The Commission on Children also supports Raised Bill 5140, An Act Concerning the use of Therapy Animals to Comfort Children Testifying in Certain Criminal Prosecutions. We coordinated the play

station after the Newtown massacre for the children and their families in the elementary school. The therapy animals helped children who could not speak, speak. The animals often brought warmth to children and a sense of contact when human touch was unbearable. We witnessed, over many months, the profound therapeutic impact of therapy animals on children needing connection, voice and security when trust in humans was tentative , at best.

We have used therapy dogs for children in homicides near and/or in schools. The results were similar to the play station in Newtown. Students welcomed the touch and security of well-trained animals. We recommend the option of therapy dogs in the courtroom as the context of the world slipping away or under for a child is similar to violent loss in cases of assault or abuse.

In closing, I note that the Commission on Children served the Concussion Task Force in an organizing and administrative capacity. The Commission would like to thank the Co-Chairs and the members of the task force, who span various areas of expertise and interest, for their leadership and service. Also, the Commission extends very special thanks to the Co-chairs of this Committee for your ongoing trust and leadership.

HOMELESS FAMILIES WITH YOUNG CHILDREN
DRAFT POLICY PACKAGE

Who is Homeless?

The term "homeless children and youth"—

*A. means individuals **who lack a fixed, regular, and adequate nighttime residence;***

B. and (B) includes—

*i. children and youths who are **sharing the housing of other persons** due to loss of housing, economic hardship, or a similar reason; are living in **motels, hotels, trailer parks, or camping grounds** due to the lack of alternative accommodations; are living in **emergency or transitional shelters;** are abandoned in hospitals; or are **awaiting foster care placement;***

*ii. children and youths who have a primary nighttime residence that is **a public or private place not designed for or ordinarily used as a regular sleeping accommodation** for human beings;*

*iii. children and youths who are **living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations**, or similar settings; and*

*iv. **migratory children** who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii)." (see footnote 1)*

- McKinney-Vento Act most recently authorized in 2001 as Part C of the Elementary and Secondary Education Act.

Introduction

Poverty, and associated homelessness among families with children under 6, continues to grow in Connecticut. Families with young children are the fastest growing segment of the homeless population in the United States, accounting for nearly 40% of the homeless.[1] This year, there are an estimated 3,000 to 9,000 families with young children who are homeless in Connecticut according to the Federal McKinney-Vento definition.[1] This estimate includes more than the 1,595 families with young children who live in an emergency shelter, transitional housing, domestic violence shelter or substance abuse treatment facilities system. Due to a lack of capacity in shelters, most families with young children in homeless situations find housing alternatives. The estimate of homeless families in Connecticut also includes the thousands of families with young children living in motels, campgrounds, cars and sharing inadequate housing who are more difficult to count (see calculations in Appendix 1). For example, of the children and youth identified as homeless by Federal State Departments of Education in FY2000, only 35 percent lived in shelters.[1]

Inadequate housing and the accompanying instability is traumatic for a family, but particularly detrimental for the long-term health and development of a young child. During the first five years, brain development is at its peak and stability, safety and a nurturing environment are critical to supporting children to build healthy social-emotional behaviors as well as intellectual abilities. For the best outcomes for children in a family, it is essential to not only quickly meet the broad range of needs facing a homeless family while they are in crisis, but also to invest in strategies to prevent homelessness and support a family's stability after a homeless episode.

[1] http://center.serve.org/nche/downloads/briefs/who_is_homeless.pdf

Homelessness is a temporary symptom of a larger problem of poverty, often intergenerational poverty. What will it take to build assets sufficient to inoculate families against homelessness and intergenerational poverty? What combination of integrated and holistic supports and strategies will be effective? State government and its ability to connect such resources as affordable housing and community planning, healthcare, early childhood services, adult literacy and job training in ways that meet the complex and ongoing needs of impoverished families plays a vital role in supporting homeless families. The following report represents a deliberate step to working better together across sectors of state government to help identify, align, stage and phase strategies that support families with young children experiencing homelessness.

Plan Development Process

Connecticut's Department of Housing has established a plan to end family homelessness by the year 2022, continuing state and national efforts to work intentionally to end homelessness among targeted populations over time as part of the Federal and State Opening Doors campaign. The non-profit community has utilized public resources and committed additional resources to address the needs of homeless families for many years and developed many effective strategies and resources. Initiatives and bodies such as Secure Jobs, the DCF Collaborative, Poverty Prevention Council and the Two-Generation Council also contribute to helping to identify solutions. All of these campaigns have brought together leaders across the state to work together and address homelessness from different angles. This policy document builds on this body of work, and complements it.

Under the leadership of Connecticut's Lieutenant Governor, Nancy Wyman, and the Office of Early Childhood's Commissioner, Dr. Myra Jones Taylor, the Connecticut Early Childhood Cabinet focused their work in 2015 on how the state could better meet the needs of young children experiencing homelessness and their families. Leadership restructured the membership of the Cabinet to include key representatives of the housing community, reconvened the Cabinet in May to introduce the new focused agenda and established a subcommittee made up of a wide range of state agency administrators and provider organizations to create a bold a legislative and administrative policy agenda.

Cabinet members heard presentations from model projects addressing homelessness currently operating in the state to gain a better understanding of the challenges and opportunities in meeting the needs of this population of children and families. Over the course of six months, subcommittee members met five times to share the work they were doing, identify ways of connecting their efforts and create a list of recommended policy and practice changes.

This report contains the recommendations created by the subcommittee which will comprise the first phase of state agency actions moving forward to better address the needs of young children and families who are homeless over the coming years. Additionally, the Office of Early Childhood (OEC), Department of Social Services (DSS), Department of Housing (DOH) and Department of Children and Families (DCF) are finding ways to align policies, practices and resources to create a more coordinated approach to case management and the provision of supports for homeless families. This involves better identification of families, including better data collection, identifying and overcoming barriers to service access, and connecting actual services and supports through case management.

THREE BOLD POLICY CHANGES

This proposal includes major budget-neutral policy changes identified by OEC, DSS and DOH to work collaboratively to better target supports to families with young children who are homeless. DCF is already a leader in developing screening tools to identify homeless families, partnerships, referral and service delivery and has agreed to support its sister agencies and continue to work together and provide leadership in this arena. Collectively, these changes will help create a better coordinated network of policy and social supports to minimize the trauma and long-term impact of homelessness on young children's development while supporting parents to create safe, stable and secure households for their families.

1) HEALTHCARE

Introduce an **intensive care coordination** model **and provide evidence-based community and home models** with community health workers, intensive care management and care coordination, infant mental health services and family-oriented mental health services for homeless families, families at-risk of homelessness and recently homeless families. DSS will explore Medicaid options to achieve this.

2) EARLY CARE AND EDUCATION

Provide homeless families with **priority access to early care and education** by:

- Making homeless families categorically eligible for the Care4Kids child care subsidy (removing other eligibility requirements, such as employment). (OEC)
- Prioritizing enrollment for children experiencing homelessness in publicly-funded early care and education settings (School Readiness, Child Day Care, Preschool Development Grant, Smart Start, etc.) and prohibiting residency and documentation requirements for those families. (OEC)

3) HOUSING

Create a preference for homeless families for turnover units in the state-administered Section 8 program. [2] DOH will request the U.S. Department of Housing and Urban Development's (HUD) approval to implement a preference for homeless individuals and families. Twenty percent of all new vouchers issued by DOH shall be offered to persons or families who are chronically homeless in accordance with the current definition.

---

[2] Note: HUD, at the Federal level, uses a different definition of homelessness than the McKinney-Vento definition used in Federal education policy. The Department of Housing uses the Federal HUD definition with 4 categories of homelessness. These categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) Individuals and families who will imminently lose their primary nighttime residence; (3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

COLLABORATIVE INTERAGENCY ACTIONS TO SUPPORT POLICY IMPLEMENTATION

State agencies must collaborate to successfully accomplish the main policy goals above. Using the collective impact model, partnering agencies will support one another's implementation of these policy changes. The subcommittee will establish an implementation plan for the identified policy proposals. Initial implementation commitments, regarding identifying families and training shelter and early care and education staff, are included below as examples.

1) **Identify and connect families and their young children who are homeless.**
    - **Use a common screening tool.**
        - Agencies will agree to use a shared screening tool, such as the "Quick Risk and Assets Family Triage" (Q-RAFT), as described below and will explore the ability to share screening data.
        - DCF will have a housing needs assessment, the Q-RAFT or other tool, completed during DCF intake and embedded in the DCF data system (SACWIS) to provide the most appropriate intervention to help families combat family homelessness or risk of homelessness.

        - Expand DCF Careline questions to include questions about the childcare and housing needs of families.
        - OEC will ensure that early care and education programs and providers are trained and screen for homelessness of children in publicly funded programs.
        - DSS will screen for homelessness as part of its eligibility determination for services.
        - OEC will work to increase developmental screenings for children in homeless families, as children who are homeless have much higher rates of developmental delays than children who are not homeless.
    - **Capture data** on homelessness.
        - OEC will include a data field for homelessness within its Early Childhood Information System for children receiving publicly funded early care and education services.
        - DSS will create the ability to flag families for homelessness or at-risk of homelessness. (For example, flag for homelessness or at-risk for homelessness for families using DSS offices, shelters or domestic violence shelters as their addresses, include a housing stability question during intake and modify its P.O. box policy.)
        - Link to the State Department of Education's (SDE) Child Find data system for housing and early care and education needs.
        - DCF's new Statewide Automated Child Welfare Information System (SACWIS) is currently under development with an anticipated 2017 release. The system will capture information from the Q-RAFT and additional assessment tools under consideration to measure family needs during the DCF CareLine call process.

- **Build referral relationships.**
  - DCF will utilize Regional Area office staff to build relationships locally with homeless shelters, homeless service and resource providers, and participate in the local Coordinated Access Network (CAN) meetings to educate, collaborate and assist families with young children in accessing stable housing and access early care and education programs,
  - OEC will ensure that a person with housing expertise is embedded into early care and education School Readiness Councils such as SDE's McKinney-Vento Liaisons or DCF Regional Area office staff.
  - DSS will allow for multiple avenues of referral of homeless families for Medicaid services including pediatricians, schools, agencies, state agencies and CANs.

2) Train program staff on serving homeless families with young children.

- **Improve programs and develop staff** to better serve homeless families to:
  - **Early childhood providers** (early care and education and home visiting programs): Identify homelessness, use best practices to educate homeless children and support the needs of the parents and young children by referring them to community services such as developmental screenings, job support and other resources.
  - **Housing staff:** Understand the developmental needs of young children, unique needs of their parents, non-housing resources available and best practices for serving a family's housing needs.
  - **Addiction services staff:** Understand the needs of young children and their parents, resources available to support families and children and best practices for meeting their young child's needs while treating their parents' addiction.

  - **DCF staff:** Enhance their understanding of current policies, practice and available resources through partnerships with local CANs, further assisting DCF families with young children to obtain stable housing and quality early care. DCF staff collaboration at the local level involving housing matters will also assist with accessing housing resources for families who receive a Family Assessment Response (FAR-non-Child Protection/unsubstantiated) and are serviced by DCF partner agencies.
- **Provide resources**
  - DOH will assist OEC with coordination of information and materials to be available at family shelters, rapid rehousing and transitional living providers.
  - DOH will coordinate with the Department of Mental Health and Addiction Services (DMHAS) on the distribution of trauma-informed care resources to all family shelters.

3) **Seek new sources of federal, state and private funding and realign existing resources to better serve homeless families with young children.**

- **Funding for housing**
  - DCF has continuously monitored all "Notice of Funding Available" (NOFA) awards from HUD in order to submit joint applications with the state and local housing authorities to apply for Federal Unification

Program (FUP) funds. These vouchers are provided to families in the child welfare system in which housing is a barrier to reunification of families or to help prevent the separation of families due to the lack of appropriate housing.

- DOH will continue to offer a schedule of competitive funding rounds for the rehabilitation, preservation and creation of affordable housing.
- DOH will introduce $30 million in Rapid Rehousing and Permanent Supporting Housing Capital Fund in January 2016.
- DOH will support the continued efforts to diversify financial products that the Connecticut Housing Finance Authority provides low- to moderate-income individuals and families for home ownership opportunities, as well as funding for the rehabilitation, preservation and creation of affordable rental housing.
- DOH will coordinate with DCF to expand the Supportive Housing for Families program by issuing over 400 Rental Assistance Program (RAP) certificates to eligible individuals over the next two years.
- Review the state regulations for the Security Deposit Guarantee Program and the Eviction and Foreclosure Prevention Program.

- **Funding for other services**
  - Continue to coordinate with philanthropic partners to fund a Secure Jobs initiative that ties job training with rapid rehousing for homeless families.
  - **Fund dedicated spaces** in early care and education programs reserved for homeless children. (OEC)
  - **Create a revolving fund** to provide immediate access for homeless families to Care4Kids funds (through a revolving fund, a shortened application time or presumptive eligibility).
  - **Create partnership opportunities** with public entities and/or philanthropic organizations to fund innovative early childhood enhancements to housing programs that specifically address the needs of babies and young children, e.g., implementation of the Early Childhood Self-Assessment Tool for Family Shelters and parent-child curricula such as SafeCare, Family Care and My Baby's First Teacher®.

Next Steps

Over the coming months, those who have worked together to create this initial plan will join with the Connecticut Opening Doors campaign to create a Families with Young Children Work Group. This work group will continue the work begun through the Early Childhood Cabinet through a more robust network of resources. Additionally, DOH will organize quarterly commissioner meetings with OEC, DSS, DMHAS, Department of Rehabilitation Services (DORS) and Department of Corrections (DOC) to ensure timely communication regarding all housing-related matters.

Families with young children need homes, families need a coordinated network of services to ensure their housing stability and young children need stable homes and a coordinated network of services to be ready for school and life. State agencies are committed to continued work in this arena.

POTENTIAL LEGISLATIVE CHANGES REQUIRED

The bulk of the policy changes noted in this report can be accomplished administratively, without requiring a legislative change. However, two changes require legislation to accomplish. These legislative changes are listed below:

RELATED TO OEC

- Provide the OEC Commissioner with the authority to create a Protective Services Categories for Care4Kids that would allow families that fall within this category (i.e. homeless families) to be eligible for the Care4Kids child care subsidy without meeting other criteria required by the subsidy (e.g. employment).

- Create a 90-day grace period for child health documentation (i.e. immunizations and health form) required by child care licensing to allow for immediate enrollment of homeless children in a licensed child care setting. *(This may require a regulatory versus statutory change.)*

Appendix 1

Estimates of Homeless Families with Children ages 0-5 in Connecticut (McKinney-Vento Definition)

Estimate Method #1	Very Low Estimate Homeless Families (McKinney-Vento)	Low Estimate Homeless Families (McKinney-Vento)
Number of families with a child ages 0-5 in any temporary shelter[3]	1,595	1,595
For every child living in a shelter, number of children doubled up[4] *"Doubled up" is defined as "sharing the housing of other persons due to loss of housing, or economic hardship."*	In Connecticut 2	Nationally 4.9
Estimated Total Homeless Families with Children under 6 (McKinney-Vento Definition)	**4,785**	**9,411**

Estimate Method #2	Low Estimate Homeless Families (McKinney-Vento)	Average Estimate Homeless Families (McKinney-Vento)
Number of families living in poverty in Connecticut (less than 100% Federal Poverty Level)[5]	30,620	30,620
Percent of children in poverty who are homeless (McKinney-Vento)[6]	CT Rate 8.90%	National Rate 27.10%
Estimated total Homeless Families with children under 6 (McKinney-Vento estimate)	**2,725**	**8,298**

[3] Includes household data for families with children under 6 passing through annually: 1,132 in emergency shelters and transitional housing (HMIS database) , 399 in domestic violence shelters (CCADV), and 64 in residential treatment facilities (DMHAS- point in time)

[4] http://www.icphusa.org/Publications/AmericanAlmanac/ (Column 1 is CT's ratio based on State Department of Education numbers of children identified as homeless in kindergarten through Grade 12 which is potentially underreported. Column 2 is the ratio based on national rates.)

[5] http://www.nccp.org/profiles/state_profile.php?state=CT&id=9

[6] http://www.icphusa.org/Publications/AmericanAlmanac/ (Column 1 is CT's percentage based on based on State Department of Education numbers of children identified as homeless in kindergarten through Grade 12 which is potentially underreported. Column 2 is the percentage based on national rates.)

Estimates of Homeless ages 0-5 in Connecticut (McKinney-Vento Definition)

Estimate Method #1	Very Low Estimate Homeless Children (McKinney-Vento)	Low Estimate Homeless Children (McKinney-Vento)
Number of families in any temporary shelter with a child ages 0-5[7]	1,595	1,595
Average number of children age 0-5 per family below 100% Federal Poverty Level in Connecticut[8]	1.35	1.35
Total number of children ages 0-5 in temporary shelter (estimate)	**2,152**	**2,152**
For every child living in a shelter, number of children doubled up[9] *"Doubled up" is defined as "sharing the housing of other persons due to loss of housing, or economic hardship."*	In Connecticut 2	Nationally 4.9
Estimated Number of Total Homeless Children (McKinney-Vento)	**6,457**	**12,914**

Estimate Method #2	Low Estimate Homeless Children (McKinney-Vento)2	Average Estimate Homeless Children (McKinney-Vento)3
Number children living in poverty in Connecticut (less than 100% Federal Poverty Level)[10]	40,689	40,689
Percent of children in poverty who are homeless (McKinney-Vento)[11]	CT Rate 8.90%	National Rate 27.10%
Number of homeless children (McKinney-Vento estimate)	**3,621**	**11,027**

[7] Includes household data for families with children under 6 passing through annually: 1132 in emergency shelters and transitional housing (HMIS database) , 399 in domestic violence shelters (CCADV), and 64 in residential treatment facilities (DMHAS- point in time)

[8] http://www.nccp.org/profiles/state_profile.php?state=CT&id=9

[9] http://www.icphusa.org/Publications/AmericanAlmanac/ (Column 1 is CT's ratio based on State Department of Education numbers of children identified as homeless in kindergarten through Grade 12 which is potentially underreported. Column 2 is the ratio based on national rates.)

[10] http://www.nccp.org/profiles/state_profile.php?state=CT&id=9

[11] http://www.icphusa.org/Publications/AmericanAlmanac/ (Column 1 is CT's percentage based on based on State Department of Education numbers of children identified as homeless in kindergarten through Grade 12 which is potentially underreported. Column 2 is the percentage based on national rates.)

Appendix 2

Connecticut Early Childhood Cabinet
Subcommittee Members – Families with Young Children Without Homes

Name/Title	Organization
Kelly Annelli, Director of Membership Organization Services	Connecticut Coalition Against Domestic Violence
Tanya Barrett, Senior Vice President	United Way of Connecticut
Rosa Biaggi, Bureau Chief	Department of Public Health
Roderick Bremby, Commissioner	Department of Social Services
Betsy Cronin, Program Director	The Connection, Inc.
Kelly Anne Day, Executive Director	New Reach, Inc.
Steve DiLella, Director of Individual and Family Support Programs	Department of Housing
Laura Dunleavy, Education Consultant	Office of Early Childhood
Anne Giordano, Early Childhood Consultant	Education Connection
William Halsey, Director of Integrated Care Unit, Division of Health Services	Department of Social Services
Sharri Lungarini, Parent	Interagency Coordinating Council of Birth to Three
Emilie Montgomery, Executive Director, Early Care and Education	Community Renewal Team
Kimberly Nilson, Program Director	Department of Children and Families
Magdalena Rosales-Alban, Chief Executive Officer	LULAC Head Start, Inc.
Peter Palermino, Program Manager	Department of Social Services
Arietta Slade, Project Director	Minding the Baby®, Yale Child Study Center Yale School of Nursing
Kim Somaroo-Rodriguez, Program Manager	Department of Children and Families
Kristina Stevens, Administrator, Clinical and Community Consultation and Support Team	Department of Children and Families
Louis Tallarita, Education Consultant	State Department of Education
Lisa Tepper Bates, Executive Director	Connecticut Coalition to End Homelessness
Elaine Zimmerman, Executive Director	Connecticut Commission on Children

HEADS UP CLINICIANS

Facts about Concussion and Brain Injury

WHERE TO GET HELP

About Concussion

Signs and Symptoms

Getting Better

Where to Get Help

Resources

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

Facts about Concussion and Brain Injury

WHERE TO GET HELP

ABOUT CONCUSSIONS

"Facts about Concussion and Brain Injury: Where to Get Help," is a publication of the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. See www.cdc.gov/TraumaticBrainInjury.

A concussion is a mild form of traumatic brain injury (TBI) caused by a bump, blow, or jolt to the head. Concussions can also occur from a fall or a blow to the body that causes the head to move rapidly back and forth. Doctors may describe these injuries as "mild" because concussions are usually not life-threatening. Even so, their effects can be serious. Understanding the signs and symptoms of a concussion can help you get better more quickly.

Leading causes of concussion

(seen in emergency departments):

- falls
- motor vehicle-related injury
- unintentionally being struck by or against an obstacle
- assaults
- playing sports

After a concussion, some people lose consciousness ("knocked out") for a short time. However, most concussions do not result in a loss of consciousness. Not being able to remember events (amnesia) prior to, or following the injury, for a period of time is another sign of concussion. Yet, some people simply feel dazed or confused.

Symptoms of concussion usually fall into four categories:

- **THINKING/REMEMBERING**, such as difficulties remembering recent events (even those immediately before and/or after the concussion), or feeling mentally "foggy"

See page 5 for more information and a full list of concussion signs and symptoms

- **PHYSICAL**, such as headaches or difficulty with bright light or loud noises
- **EMOTIONAL/MOOD**, such as irritability, sadness, or nervousness
- **SLEEP DISTURBANCE**, such as sleeping more or less than usual

Most people with a concussion recover quickly and fully. But for some people, symptoms can last for days, weeks, or longer. In general, recovery may be slower among older adults, young children, and teens. Those who have had a concussion in the past are also at risk of having another one and may find that it takes longer to recover if they have another concussion.

MEDICAL HELP

People with a concussion need to be seen by a doctor. While most are seen in an emergency department or a doctor's office, some people must stay in the hospital overnight.

Your doctor may do a scan of your brain (such as a CT scan) or other tests. Other tests, known as "neuropsychological" or "neurocognitive" tests, assess your learning and memory skills, your ability to pay attention or concentrate, and how quickly you can think and solve problems. These tests can help your doctor identify the effects of a concussion. Even if the concussion doesn't show up on these tests, you may still have a concussion.

Persons taking blood thinners should be seen immediately by a health care provider if they have a bump or blow to the head even if they do not have any symptoms listed on page 5.

Your doctor will send you home with important instructions to follow. Be sure to follow all of your doctor's instructions carefully.

If you are taking medications—prescription, over-the-counter medicines, or "natural remedies"—or if you drink alcohol or take illicit drugs, tell your doctor. Also, tell your doctor if you are taking blood thinners (anticoagulant drugs), such as Coumadin and aspirin, because they can increase the chance of complications.

DANGER SIGNS – ADULTS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. Contact your doctor or emergency department right away if you have any of the following danger signs after a bump, blow, or jolt to the head or body:

- Headache that gets worse and does not go away
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech

The people checking on you should take you to an emergency department right away if you:

- Look very drowsy or cannot be awakened
- Have one pupil (the black part in the middle of the eye) larger than the other
- Have convulsions or seizures
- Cannot recognize people or places
- Are getting more and more confused, restless, or agitated
- Have unusual behavior
- Lose consciousness (a brief loss of consciousness should be taken seriously and the person should be carefully monitored).

DANGER SIGNS – CHILDREN

Take your child to the emergency department right away if they received a bump, blow, or jolt to the head or body, and:

- Have any of the danger signs for adults listed above
- Will not stop crying and cannot be consoled
- Will not nurse or eat

SYMPTOMS OF CONCUSSION

PERSONS OF ALL AGES

"I just don't feel like myself."

Most people with a concussion have one or more of the symptoms listed below and recover fully within days, weeks or a few months. But for some people, symptoms of concussion can last even longer. Generally, if you feel that "something is not quite right," or if you are feeling "foggy," you should talk with your doctor.

Concussion symptoms are often grouped into four categories, including:

THINKING/ REMEMBERING	PHYSICAL	EMOTIONAL/ MOOD	SLEEP DISTURBANCE
• Difficulty thinking clearly • Feeling slowed down • Difficulty concentrating • Difficulty remembering new information	• Headache • Nausea or vomiting (early on) • Balance problems • Dizziness • Fuzzy or blurry vision • Feeling tired, having no energy • Sensitivity to noise or light	• Irritability • Sadness • More emotional • Nervousness or anxiety	• Sleeping more than usual • Sleeping less than usual • Trouble falling asleep

Some of these symptoms may appear right away, while others may not be noticed for days or months after the injury, or until the person starts resuming their everyday life and more demands are placed upon them. Sometimes, people do not recognize or admit that they are having problems. Others may not understand why they are having problems and what their problems really are, which can make them nervous and upset.

The signs and symptoms of a concussion can be difficult to sort out. Early on, problems may be missed by the person with the concussion, family members, or doctors. People may look fine even though they are acting or feeling differently.

YOUNG CHILDREN

Very young children (i.e., infants, toddlers, and preschoolers) often bump and bruise their heads. This can happen as a result of motor vehicle crashes, falls, getting hit in the head with a ball or toy, or from tricycle/bike accidents.

Sometimes these events can be serious and result in a concussion.

Young children can have the same symptoms of a concussion as older children, but it is harder for them to let others know how they are feeling. In addition to the symptoms mentioned on page 5, call your child's doctor right away if your child seems to be getting worse or if you notice any of the following:

- Crying more than usual
- Headache that will not go away
- Change in the way they play, perform or act at school
- Change in nursing, eating, or sleeping patterns
- Becoming easily upset or increased temper tantrums
- Sad mood
- Lack of interest in usual activities or favorite toys
- Loss of new skills, such as toilet training
- Loss of balance, unsteady walking
- Poor attention

OLDER ADULTS

Because concussions are often missed or misdiagnosed among older adults, be especially alert if you know that an older adult has fallen or has a fall-related injury, such as a hip fracture. Older adults may have a higher risk of serious complications from a concussion, such as bleeding on the brain. Headaches that get worse or increased confusion are signs of this complication. If they occur, see a doctor right away. Older adults often take blood thinners; if they do, they should be seen immediately by a health care provider if they have a bump or blow to the head or body even if they do not have any of the symptoms listed on page 5.

GETTING BETTER

"Sometimes the best thing you can do is just rest and then try again later."

Although most people recover fully after a concussion, how quickly they improve depends on many factors. These factors include how severe their concussion was, their age, how healthy they were before the concussion, and how they take care of themselves after the injury.

Some people who have had a concussion find that at first it is hard to do their daily activities, their job, to get along with everyone at home, or to relax. Ignoring your symptoms and trying to "tough it out" often makes symptoms worse.

Rest is very important after a concussion because it helps the brain to heal. You'll need to be patient because healing takes time. Only when the symptoms have reduced significantly, in consultation with your doctor, should you slowly and gradually return to your daily activities, such as work or school. If your symptoms come back or you get new symptoms as you become more active, this is a sign that you are pushing yourself too hard. Stop these activities and take more time to rest and recover. As the days go by, you can expect to gradually feel better.

If you already had a medical condition at the time of your concussion (such as chronic headaches), it may take longer for you to recover from the concussion. Anxiety and depression

may also make it harder to adjust to the symptoms of a concussion. While you are healing, you should be very careful to avoid doing anything that could cause a bump, blow, or jolt to the head or body. On rare occasions, receiving another concussion before the brain has healed can result in brain swelling, permanent brain damage, and even death, particularly among children and teens.

After you have recovered from your concussion, you should protect yourself from having another one. People who have had repeated concussions may have serious long-term problems, including chronic difficulty with concentration, memory, headache, and occasionally, physical skills, such as keeping one's balance.

TIPS FOR HEALING - ADULTS

Tips to help you get better:

- Get plenty of sleep at night, and rest during the day.
- Avoid activities that are physically demanding (e.g., heavy housecleaning, weightlifting/working-out) or require a lot of concentration (e.g., balancing your checkbook). They can make your symptoms worse and slow your recovery.
- Avoid activities, such as contact or recreational sports, that could lead to a second concussion. (It is best to avoid roller coasters or other high speed rides that can make your symptoms worse or even cause a concussion.)
- When your doctor says you are well enough, return to your normal activities gradually, not all at once.
- Because your ability to react may be slower after a concussion, ask your doctor when you can safely drive a car, ride a bike, or operate heavy equipment.
- Talk with your doctor about when you can return to work. Ask about how you can help your employer understand what has happened to you.
- Consider talking with your employer about returning to work gradually and about changing your work activities or schedule until you recover (e.g., work half-days).
- Take only those drugs that your doctor has approved.
- Do not drink alcoholic beverages until your doctor says you are well enough. Alcohol and other drugs may slow your recovery and put you at risk of further injury.
- Write down the things that may be harder than usual for you to remember.

- If you're easily distracted, try to do one thing at a time. For example, don't try to watch TV while fixing dinner.
- Consult with family members or close friends when making important decisions.
- Do not neglect your basic needs, such as eating well and getting enough rest.
- Avoid sustained computer use, including computer/video games early in the recovery process.
- Some people report that flying in airplanes makes their symptoms worse shortly after a concussion.

TIPS FOR HEALING - CHILDREN

Parents and caregivers of children who have had a concussion can help them recover by taking an active role in their recovery:

- Having the child get plenty of rest. Keep a regular sleep schedule, including no late nights and no sleepovers.
- Making sure the child avoids high-risk/ high-speed activities such as riding a bicycle, playing sports, or climbing playground equipment, roller coasters or rides that could result in a second bump, blow, or jolt to the head or body. Children should not return to these types of activities until the doctor says they are well enough.
- Giving the child only those drugs that are approved by the pediatrician or family physician.
- Talking with the doctor about when the child should return to school and other activities and how the parent or caregiver can help the child deal with the challenges that the child may face. For example, your child may

need to spend fewer hours at school, rest often, or require more time to take tests.

- Sharing information about concussion with parents, siblings, teachers, counselors, babysitters, coaches, and others who interact with the child helps them understand what has happened and how to meet the child's needs.

WHERE TO GET HELP

HELP FOR PEOPLE WITH CONCUSSION

"It was the first time in my life that I couldn't depend on myself."

There are many people who can help you and your family as you recover from a concussion. You do not have to do it alone.

Show this booklet to your doctor or health care provider and talk with them about your concerns. Ask your doctor about whether you need specialized treatment and about the availability of rehabilitation programs.

Your doctor can help you find a health care provider who has special training in treating concussion. Early treatment of symptoms by a specialist may speed recovery. Your doctor may refer you to a neuropsychologist, neurologist, or specialist in rehabilitation.

Keep talking with your doctor, family members, and loved ones about how you are feeling, both physically and emotionally. If you do not think you are getting better, tell your doctor.

For more information, see the Resources on page 15.

HELP FOR FAMILIES AND CAREGIVERS

"My husband used to be so calm. But after his injury, he started to explode over the littlest things. He didn't even know that he had changed."

When someone close to you has a concussion or a more serious brain injury, it can be hard to know how best to help. They may say that they are "fine," but you can tell from how they are acting that something has changed.

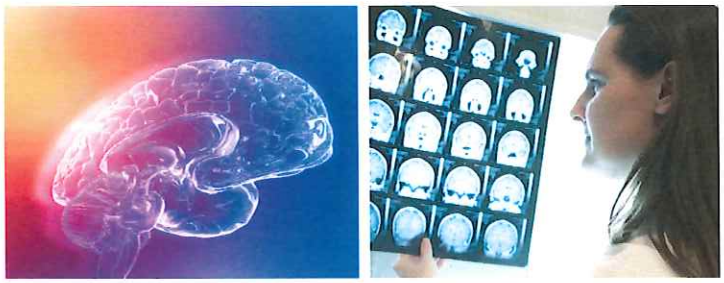
If you notice that your family member or friend has symptoms of a concussion that are getting worse, talk to them and their doctor about getting help. They may need help if you can answer YES to any of the following questions:

- Are any of the concussion symptoms substantially affecting their life activities (such as feeling restricted in their activities due to symptoms, performance in school or at work has changed, unhappy with life changes)?
- Has their personality changed?
- Do they get angry for no reason?
- Do they get lost or easily confused?
- Do they have more trouble than usual making decisions?

You might want to talk with people who share your experience. The Brain Injury Association of America can put you in contact with people who can help (see page 15).

RESOURCES

"I thought I was all alone, but I'm not.
There are lots of people out there who understand
what I've been through."



Several groups help people and their families deal with concussion and more serious brain injuries. They provide information and put people in touch with local resources, such as support groups, rehabilitation services, and a variety of health care professionals.

- CDC's Injury Center has created resources and conducts research to help prevent concussion and more serious brain injuries and improve outcomes for survivors. For more information contact CDC toll-free at 1-800-CDC-INFO (1-800-232-4636) or visit CDC's Injury Center on the Web at www.cdc.gov/TraumaticBrainInjury.

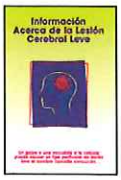
- The Brain Injury Association of America (BIAA) has a national network of many state affiliates and hundreds of local chapters and support groups across the country that provide help in your community.

You can reach BIAA by calling the toll-free National Brain Injury Information Center at 1-800-444-6443. You can also get information through their website at www.biausa.org. Both the help line and the website can provide you with information about the BIAA affiliate closest to you.

- The Defense and Veterans Brain Injury Center (DVBIC) works to ensure that active duty military and veterans with brain injury receive the best evaluation, treatment, and follow-up. You can reach DVBIC by calling toll-free at 1-800-870-9244 or by visiting their website at www.dvbic.org.

- For more information about TBI in the military, including an interactive website for service members, veterans, and families and caregivers, please visit: www.TraumaticBrainInjuryatoz.org.

ADDITIONAL CDC CONCUSSION RESOURCES

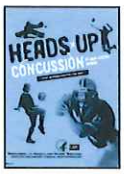


Information about Mild Brain Injuries
(Información Acerca de la Lesión Cerebral Leve) booklet

This booklet is written for Spanish-speaking people with brain injuries and their family members or caregivers. The booklet provides information about brain injury, its symptoms, tips for healing, and resources.

Heads Up: Brain Injury in Your Practice initiative

Physicians and other health care providers can play a key role in helping to reduce the occurrence of mild traumatic brain injury (TBI) or concussion by educating patients and the community about risks and how to prevent these injuries. This initiative provides physicians with tools and information for improving the clinical diagnosis and management of mild TBI.



Heads Up: Concussion in High School Sports initiative

Concussions can happen to any athlete—male or female—in any sport. This initiative, developed for high school coaches, athletic directors and trainers, contains practical, easy-to-use information, such as a video, guide for coaches, wallet card, clipboard sticker, posters, and fact sheets.

Heads Up: Concussion in Youth Sports initiative

To help ensure the health and safety of young athletes, CDC developed the "Heads Up: Concussion in Youth Sports" initiative to offer information about concussions to youth sports coaches, administrators, parents, and athletes. This initiative provides information about preventing, recognizing, and responding to a concussion and includes fact sheets for coaches, athletes, and parents, and a clipboard, magnet, poster, and quiz.

Help Seniors Live Better, Longer: Prevent Brain Injury initiative

This initiative was developed for caregivers and children of older adults to raise their awareness of ways to prevent, recognize, and respond to fall-related TBI among adults ages 75 and older. As part of this initiative, CDC developed English- and Spanish-language materials for older adults and their caregivers, including a brochure, booklet, fact sheet, magnet, posters, and e-cards.

For more information and resources, including multiple fact sheets available on concussion and TBI, or to order additional materials free-of-charge, call CDC toll-free at 1-800-CDC-INFO (1-800-232-4636) or visit CDC's Injury Center on the Web at www.cdc.gov/TraumaticBrainInjury .

A bump, blow, or jolt to the head can cause a concussion, a type of traumatic brain injury (TBI). Concussions can also occur from a fall or a blow to the body that causes the head to move rapidly back and forth.

Some symptoms of a concussion are:

- Headaches that won't go away
- Having more trouble than usual remembering things or concentrating
- Confusion about recent events
- Feeling tired all of the time
- Feeling sad or anxious
- Becoming easily irritated or angry for little or no reason

For more information about danger signs, tips for getting better, and where to go for help, look inside this booklet.

PARTICIPATING ORGANIZATIONS

American College of Emergency Physicians
Brain Injury Association of America
Children's National Medical Center
Emergency Nurses Association
Human Resources and Services Administration
Indian Health Service
National Academy of Neuropsychology
National Association of State Head Injury Administrators
North American Brain Injury Society
Special Olympics International

HEADS UP CLINICIANS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC

2010